Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: PRESBYTERIAN HOSPITAL OF DALLAS P.O. BOX 203500 AUSTIN, TX 78720-3500	MFDR Tracking #: M4-08-4562-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Carrier's Austin Representative Box #: TEXAS MUTUAL INSURANCE CO Box #: 54	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "2 day in pt day was pre-auth. Nurse forgot to transmit the update because it was approved after the initial pre-auth complete. Prim. DX code is a trauma code & bill should be excluded & paid @ F&R rate. Historical data shows F&R is 75% of BC on trauma prim dx codes. Carrier has underpaid by $13792.22. $200.00 pt Resp for private room."

Amount in Dispute: $20,455.38

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor believes 75% of billed charges is fair and reasonable because historically insurance carriers have paid that. The current inpatient hospital fee guideline offers no guidance regarding the MAR for trauma admissions except they are to be paid a fair and reasonable reimbursement. Texas Mutual believes the current hospital fee guideline MAR of 143% of Medicare, absent implant billing from separate provider other than the hospital, is fair and reasonable." "Texas Mutual took the 143% and applied it to the 2007 dates of service through Medicare's PC Pricer for its Inpatient Prospective payment System based on the DRG the requestor listed on it bill. The amount from the Pricer is $7,616.16. (Exhibit) That amount multiplied by 1.43 is $10,891.75 minus Texas Mutual's previous payment is $4,228.59." "Texas Mutual considers that to be fair and reasonable payment and is willing to settle this dispute with the requestor for that additional amount."

Response Submitted by: Richard Ball, Texas Mutual Insurance Co., 6210 East Hwy 290, Austin, TX 78723

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
5/15/2007 through 5/17/2007	930, CAC-W1, CAC-W10, CAC-62, CAC-97, 480, 719, 730, CAC-W4, CAC-143, 420, 426, 891, 878, 18	Inpatient Surgery Admission	$20,455.38	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on March 14, 2008.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code(s):
   - 930-Pre-authorization was for outpatient surgery only. Allowing 1 day surgical per diem as reasonable and necessary.
   - 930-Pre-authorization required, reimbursement denied.
   - CAC- W1-Workers Compensation state fee schedule adjustment.

- CAC-W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
- CAC-62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
- CAC-97-Payment is included in the allowance for another service/procedure.
- 480-Reimbursement based on the Acute Care Inpatient Hospital Fee Guideline per diem rate allowances.
- 719-Reimbursed at carrier's fair & reasonable; cost data unavailable for facility. Additional payment may be considered if data submitted.
- 730-Denied as included in per diem rate.
- CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
- CAC-143-Portion of payment deferred.
- 420-Supplemental payment.
- 426-Reimbursed to fair and reasonable.
- 891-The insurance company is reducing or denying payment after reconsideration.
- 878-Duplicate appeal. Request medical dispute resolution through DWC for continued disagreement of original appeal decision.
- 18-Duplicate claim/service.

2. The respondent denied reimbursement for the disputed services based upon "930" and CAC-62". Division rule at 28 TAC §134.600(p)(1) effective May 2, 2006, requires preauthorization for "inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay." The Division finds that on 5/13/2007 the requestor obtained preauthorization approval for "ORIF Left Calcaneous, 2 day LOS"; therefore, the insurance carrier's EOB denial reason codes of "930" and "CAC-62 " are not supported. The Division also finds that the respondent upon reconsideration issued payment based upon fair and reasonable reimbursement. Therefore, a pre-authorization issue does not exist and the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.
3. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.
4. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 825.0. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
5. Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
6. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
7. Division rule at 28 TAC §133.307(c)(2)(E), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report, the requestor did not submit a copy of the anesthesia record, post-operative care record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(E).
8. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee

guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(F)(iii).

9. Division rule at 28 TAC §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(F)(iv).

10. Division rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

    - The requestor's rationale for increased reimbursement from the *Table of Disputed Services* states that "2 day in pt day was pre-auth. Nurse forgot to transmit the update because it was approved after the initial pre-auth complete. Prim. DX code is a trauma code & bill should be excluded & paid @ F&R rate. Historical data shows F&R is 75% of BC on trauma prim dx codes. Carrier has underpaid by $13792.22. $200.00 pt Resp for private room."
    - The requestor does not discuss or explain how payment of $20,455.38 would result in a fair and reasonable reimbursement.
    - The requestor did not discuss or explain how it determined that the 75% of charges would yield a fair and reasonable reimbursement
    - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
    - The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

      "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."
    - The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
    - The requestor did not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

    The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

11. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(E), §133.307(c)(2)(F)(iii), §133.307(c)(2)(F)(iv) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

		8/23/2011
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.